No. 02-1826

In the
Supreme Court of the United States

ROBERT ROARK, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF HIS DECEASED WIFE, GWEN ROARK,
Petitioner,

v.

HUMANA, INC., HUMANA HEALTH PLAN OF TEXAS, INC. (D/B/A, HUMANA HEALTH PLAN OF TEXAS (DALLAS), HUMANA HEALTH PLAN OF TEXAS (SAN ANTONIO), AND HUMANA HEALTH PLAN OF TEXAS (CORPUS CHRISTI)), AND HUMANA HMO TEXAS, INC.,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals for the Fifth Circuit

BRIEF OF THE STATES OF TEXAS, ALABAMA, CALIFORNIA, DELAWARE, HAWAII, MINNESOTA, MISSOURI, NEVADA, OKLAHOMA, OREGON, UTAH, WASHINGTON, D.C., WEST VIRGINIA, WISCONSIN, WYOMING AND THE COMMONWEALTH OF PUERTO RICO AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases **Page**

FEDERAL STATUTES

STATE STATUTES

INTEREST OF AMICI CURIAE

The State *amici curiae*, through their Attorneys General, respectfully submit this brief in support of the petition for a writ of certiorari. States have a vital interest in protecting their power to regulate in traditional areas of state concern, such as the health and safety of their citizens. Nothing in the Employee Retirement Income Security Act of 1974 (ERISA) evidences an intent to eliminate the States' role in regulating health care. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). And, the States have a corresponding interest in ensuring that the scope of preemption by ERISA is not extended beyond Congress's stated intent.

The Texas Health Care Liability Act §88.002(a) directly serves the State's interest in protecting the health and safety of its citizens. It provides a cause of action against a health maintenance organization (HMO) that breaches its duty to exercise ordinary care when making health care treatment decisions. The State of Texas, in its role as regulator of health care, has determined that when an HMO effectively directs the provision of health care, and that direction results in the loss of life or limb, the HMO should be held responsible for its erroneous medical judgment.

Humana's claim to engage in medical decision-making without regard for state law cannot be squared with congressional intent, this Court's jurisprudence, and federalism concerns. The State *amici curiae* ask the Court to grant the petition and hold that a state-law medical negligence claim alleged under §88.002(a) arising out of an HMO's medical-necessity decision is not preempted by ERISA.

SUMMARY OF THE ARGUMENT

Traditionally, States have been the primary protectors of the public health and welfare. The Court has, on many occasions, noted the historic state function of regulating health care. Moreover, since it issued *Travelers* in 1995, it has expressly recognized that Congress did not intend to supplant state law regarding health care in enacting ERISA.

Nonetheless, because it perceived itself to be bound by prior circuit precedent, the panel below followed the Fifth Circuit's earlier decision in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (CA5 1992), to hold that a claim under a Texas statute requiring that HMO health care decisions regarding medical necessity be executed using ordinary care was preempted by ERISA. The panel's decision is in direct conflict with the Second Circuit's decision in *Cicio v. Does*, 321 F.3d 83 (CA2 2003), construing a similar New York law.

HMO medical-necessity determinations, just like treatment decisions made by a physician, involve the exercise of medical judgment—an area squarely within the States' core power to pass regulations to protect the health and welfare of their citizens. The State *amici* maintain that because there is no evidence of congressional intent to supplant the States' traditional role in regulating medical judgment, the regulation of HMO treatment decisions—decisions of medical necessity—are not preempted by ERISA.

The Court should grant the petition for writ of certiorari to resolve the conflict between the circuits and to clarify the bounds of ERISA preemption in this area of traditional state regulation.

ARGUMENT

I. THE QUESTION WHETHER ERISA PREEMPTS TRADITIONAL STATE REGULATION OF HEALTH CARE IS AN ISSUE OF GREAT IMPORTANCE TO THE STATES.

State laws regulating medical judgment and health care have historically been matters of state concern. *E.g.*, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (noting that the "historic police powers of the State include the regulation of matters of health and safety"). The Court has recognized that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestations of congressional purpose." *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000).

Because "[n]othing in the language of [ERISA] or the context of its passage indicates Congress chose to displace general health care regulation," *Travelers*, 514 U.S., at 661, state statutes that regulate the core concerns of public health and safety ought to remain outside the scope of ERISA's preemption.

The statute at issue in this case—Texas Health Care Liability Act §88.002(a)—is one such public health and safety statute. It furthers the State's interest in protecting the health and welfare of its citizens by (1) imposing upon HMOs a duty to use ordinary care when making health care treatment decisions and (2) creating a cause of action against an HMO for harm that results from its failure to exercise such ordinary care.

The State *amici* believe that when an HMO, under the guise of determining coverage, makes a decision that encroaches on traditional medical decision-making and impacts treatment—a decision termed a "mixed-eligibility decision"—the HMO ought to be held accountable for its actions if they fall below the recognized standard of care. But the panel opinion below held to the contrary by holding that a claim under §88.002(a) for a mixed-eligibility decision is preempted by ERISA. *Roark v. Humana, Inc.*, 307 F.3d

298, 315 (CA5 2002). Thus, in the Fifth Circuit, "HMO's can escape all liability if they instruct their doctors to recommend every possible treatment and leave the real decision to HMO administrators." *Id.*

The Fifth Circuit's holding undermines the States' traditional power to regulate health care by expanding the ERISA preemption beyond Congress' intent and into an area of core State powers. It is counter to this Court's ERISA preemption jurisprudence and to principles of federalism. The Court should grant the petition to clarify that mixed questions of eligibility and treatment do not fall within the scope of ERISA preemption and are therefore a proper subject for State regulation.

II. THE COURTS OF APPEALS ARE SPLIT ON THE QUESTION WHETHER ERISA PREEMPTS STATE MEDICAL MALPRACTICE LAW AS IT APPLIES TO MIXED QUESTIONS OF ELIGIBILITY AND TREATMENT.

There is a split among the courts of appeals on the issue whether ERISA preempts state laws that regulate mixed eligibility and treatment decisions. The panel opinion below, believing itself bound by prior Fifth Circuit precedent in *Corcoran*, 965 F.2d, at 1321, held that it does.[1] The Second Circuit, on the other hand, recently held that it does not. *Cicio v. Does*, 321 F.3d, at 104.

In *Cicio*, the Second Circuit addressed the question whether a state law malpractice action, if based on a "mixed-eligibility and treatment decision," is subject to ERISA preemption when the state

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1. Although the Fifth Circuit upheld a facial challenge to §88.002(a) in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526, 534 (CA5 2000), *vacated on other grounds sub nom. Montemayor v. Corporate Health Ins.*, 536 U.S. 935, 122 S.Ct. 2617 (2002), the panel concluded it could not automatically extend *Corporate Health*'s holding to the challenge presented in this case. *Roark*, 307 F.3d, at 308, n.11.

law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms. *Id.*, at 102. The Second Circuit held that the ERISA preemption does not apply.

In arriving at this conclusion, the court observed that the prospective utilization review typically performed by HMOs blurs the boundaries between the traditionally "distinct sphere of professional dominance and autonomy" of the medical profession on the one hand, and the managerial domain of the HMO on the other. *Id.*, at 98-99. The court concluded, therefore, that decisions with a medical component—*i.e.*, involving the exercise of medical judgment—and which are made by HMO staff, rather than a physician, involve mixed questions of eligibility and treatment and are beyond the scope of the ERISA preemption.

The States agree with the Second Circuit and respectfully submit that it accurately applies this Court's ERISA preemption jurisprudence.

III. THE COURT SHOULD GRANT THE PETITION TO CLARIFY THAT MIXED QUESTIONS OF ELIGIBILITY AND TREATMENT DO NOT FALL WITHIN ERISA PREEMPTION.

The Court's ERISA preemption jurisprudence has developed considerably over the years. Prior to 1995, the Court construed the ERISA preemption broadly with a "common sense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46-47 (1987) (citations omitted). But, beginning with *Travelers* in 1995, the Court reined in the broad interpretation of "relates to," noting "if 'relates to' is taken to the furthest stretch of its indeterminancy, preemption will never run its course, for 'really, universally, relations stop nowhere.'" 514 U.S., at 655. Under the cases that are

collectively referred to as "the trilogy,"[2] the Court has developed a more restrained view of ERISA preemption that requires instead an "indication in ERISA . . . [or] its legislative history . . . [of an] intent on the part of Congress to preempt a traditionally state-regulated substantive law." *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316, 331 (1997).

The Court further restricted the scope of the ERISA preemption with its decisions in *Pegram v. Herdrich*, 530 U.S., at 236 (holding that HMO's mixed-eligibility and treatment decisions were not fiduciary acts under ERISA and recognizing that "ERISA was not enacted . . . in order to federalize malpractice litigation"), *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)(holding that state statute establishing independent review of an HMO's medical necessity decisions was not preempted by ERISA), and *Kentucky Association of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (2003) (holding that state's "any willing provider" statute that required HMOs to accept any health care provider willing to abide by its conditions was not preempted by ERISA).

The preemption trilogy, in combination with *Pegram*, *Moran*, and *Miller*, reflect the Court's recognition that the States may, without running afoul of the ERISA preemption, regulate HMO medical-necessity decision-making. Indeed, the Court has gone so far as to say that it has thrown "cold water" on the idea that state regulation of health and safety is necessarily preempted even when it overlaps with rights protected by ERISA. *Pegram*, 530 U.S., at 237. Accordingly, it follows that the States can, free from the bounds of ERISA, establish a remedy for injury that results when an HMO makes a medical-necessity decision that falls below the recognized standard of care.

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2. *Travelers Ins. Co.*, 514 U.S., at 645, *Dillingham Constr.*, 519 U.S., at 316, and *De Buono*, 520 U.S., at 806, together comprise "the trilogy" in ERISA preemption law.

As aptly explained by the Pennsylvania Supreme Court in *Pappas v. Asbel*, 564 Pa. 407, 417, 768 A.2d 1089, 1095 (Pa. 2001), *cert. denied sub nom. U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002):

> While *Travelers* and *Pegram* deal with different aspects of ERISA, for our present purposes, they share common ground. *Travelers* instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. *Pegram* instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach.

Thus, concluded the Pennsylvania court, a claim against an HMO arising out of a mixed decision is, under *Pegram*, subject to state medical malpractice law, and, under *Travelers*, is not preempted by ERISA. *Id.*

More recently, the Florida Supreme Court relied on *Pappas* in determining that "state law causes of actions against HMOs based upon allegations of direct and vicarious liability for negligence in the provision of medical services to member patients" are not preempted by ERISA. *Villazon v. Prudential Health Care Plan, Inc.*, 843 So.2d 842, 848-849 (Fla. 2003).

In addition, the Ninth Circuit, in a decision concerning the Federal Employees Health Benefits Act (FEHBA),[3] has reached the mixed-eligibility and treatment question in that context and found no preemption. *Roach v. Mail Handlers Benefit Plan*, 298 F.3d 847 (CA9 2002). In *Roach*, a federal employee covered by the FEHBA

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3. The Fifth Circuit has interpreted the "relates to" language in the ERISA and FEHBA preemption sections "similarly." *Corporate Health*, 215 F.3d, at 539; *accord Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (CA5 1993).

sued her plan administrator, Mail Carriers, and its subcontractor, Access Health, Inc., for malpractice. The court, citing to *Moran*, determined Roach's malpractice claim was not preempted by FEHBA because nothing in FEHBA indicated a clear and manifest intent by Congress to preempt the "quintessentially state-law standards of reasonable medical care." *Id.*,at 850 (citing *Moran*, 536 U.S., at 387).

The Second Circuit, the Pennsylvania and Florida Supreme Courts, and the Ninth Circuit in a related FEHBA case have all reached the correct result. State efforts to regulate the provision of health care by requiring HMO medical-necessity decisions to be executed using ordinary care, and the creation of a malpractice claim to redress injury caused by a failure to abide by that standard, should not be swept into—and thus invalidated by—ERISA preemption. The Fifth Circuit's opinion at issue here conflicts with those decisions and is out of step with this Court's evolving ERISA jurisprudence respecting the States' fundamental power to regulate health care.

CONCLUSION

The Court should grant the petition for writ of certiorari.

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